

Facility Name & ID Number Heritage Manor-Colfax# 0041020 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>60</u>	Skilled (SNF)	<u>60</u>	<u>21,960</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>60</u>	TOTALS	<u>60</u>	<u>21,960</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,471</u>	<u>8,509</u>	<u>1,809</u>	<u>15,789</u>	8
9	SNF/PED			<u>0</u>		9
10	ICF					10
11	ICF/DD					11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,471</u>	<u>8,509</u>	<u>1,809</u>	<u>15,789</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 71.90%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 1963

J. Was the facility purchased or leased after January 1, 1978?

YES ☐

Date _____

NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified _____

and days of care provided _____

1,809Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐

Tax Year: _____

Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number Heritage Manor-Colfax

0041020

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	138,783	7,501		146,284		146,284	2,240	148,524			1
2	Food Purchase		51,802		51,802		51,802		51,802			2
3	Housekeeping	41,492	10,158		51,650		51,650		51,650			3
4	Laundry	36,554	4,807		41,361		41,361		41,361			4
5	Heat and Other Utilities			47,288	47,288		47,288	686	47,974			5
6	Maintenance	30,697	24,233	23,662	78,592		78,592	8,036	86,628			6
7	Other (specify):*											7
8	TOTAL General Services	247,526	98,501	70,950	416,977		416,977	10,962	427,939			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	649,285	39,841	47,466	736,592		736,592		736,592			10
10a	Therapy		135,182	137,556	272,738	(209,533)	63,205	64,467	127,672			10a
11	Activities	25,929	892		26,821		26,821		26,821			11
12	Social Services	24,271		2,889	27,160		27,160		27,160			12
13	Nurse Aide Training	354	101		455		455	1,187	1,642			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	699,839	176,016	195,111	1,070,966	(209,533)	861,433	65,654	927,087			16
	C. General Administration											
17	Administrative	51,597			51,597		51,597	40,339	91,936			17
18	Directors Fees							3,262	3,262			18
19	Professional Services			143,709	143,709		143,709	(133,453)	10,256			19
20	Dues, Fees, Subscriptions & Promotions			48,408	48,408	(32,940)	15,468	(4,009)	11,459			20
21	Clerical & General Office Expenses	69,544	5,785	12,237	87,566		87,566	81,203	168,769			21
22	Employee Benefits & Payroll Taxes			220,804	220,804		220,804	20,918	241,722			22
23	Inservice Training & Education			1,021	1,021		1,021	332	1,353			23
24	Travel and Seminar			4,637	4,637		4,637	(2,638)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			37,833	37,833		37,833	1,224	39,057			26
27	Other (specify):*											27
28	TOTAL General Administration	121,141	5,785	468,649	595,575	(32,940)	562,635	7,178	569,813			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,068,506	280,302	734,710	2,083,518	(242,473)	1,841,045	83,794	1,924,839			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number

Heritage Manor-Colfax

#0041020

Report Period Beginning:

01/01/2004

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			65,849	65,849		65,849	6,976	72,825			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,864	38,864		38,864	(79)	38,785			32
33	Real Estate Taxes			28,620	28,620		28,620		28,620			33
34	Rent-Facility & Grounds							3,971	3,971			34
35	Rent-Equipment & Vehicles			5,422	5,422		5,422	(783)	4,639			35
36	Other (specify):*											36
37	TOTAL Ownership			138,755	138,755		138,755	10,085	148,840			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					209,533	209,533		209,533			39
40	Barber and Beauty Shops		5	4,857	4,862		4,862		4,862			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					32,940	32,940		32,940			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		5	4,857	4,862	242,473	247,335		247,335			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,068,506	280,307	878,322	2,227,135		2,227,135	93,879	2,321,014			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Heritage Manor-Colfax

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,346)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(79)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(328)	20		17
18	Fines and Penalties				18
19	Entertainment	(7,540)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,075)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(5,886)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (17,254)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	111,133		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 111,133		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 93,879		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Heritage Manor-Colfax

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		(2,346)	35
6		0	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(328)	20
18			18
19			24
20		0	27
21			21
22		(1,075)	19
23			23
24		0	27
25		(5,886)	20
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(9,635)	49

Summary A

12/31/2004

[illegible]

Summary B

12/31/2004

[illegible]

Facility Name & ID Number Heritage Manor-Colfax# 0041020Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V	10a Adjustment for Related Organization	22,148	GreenTree Therapy	100.00%	21,338	(810)	2
3	V							3
4	V	19 Adjustment for Related Organization	142,634	Heritage Enterprises, Inc.	100.00%		(142,634)	4
5	V							5
6	V	10a Adjustment for Related Organization	134,643	GreenTree Pharmacy	100.00%	199,920	65,277	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 299,425			\$ 221,258	\$ * (78,167)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Colfax# 0041020Report Period Beginning: 01/01/2004Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 2,240	\$ 2,240
16	V	2 Food Purchase				0	
17	V	3 Housekeeping				0	
18	V	4 Laundry				0	
19	V	5 Heat & Other Utilities				686	686
20	V	6 Maintenance				8,036	8,036
21	V	7 Other				0	
22	V	9 Medical Director				0	
23	V	10 Nursing & Medical Records				0	
24	V	11 Activities				0	
25	V	12 Social Service				0	
26	V	13 Nurse Aide Training				1,187	1,187
27	V	14 Program Transportation				0	
28	V	15 Other				0	
29	V	17 Administrative				40,339	40,339
30	V	18 Directors Fees				3,262	3,262
31	V	19 Professional Services				10,256	10,256
32	V	20 Fees, Subscription, Promotions				2,205	2,205
33	V	21 Clerical & General Office Expenses				81,203	81,203
34	V	22 Employee Benefits & Payroll Taxes				20,918	20,918
35	V	23 Inservice Training & Education				332	332
36	V	24 Travel and Seminar				4,902	4,902
37	V	25 Other Admin. Staff Transportation				0	
38	V	26 Insurance-Prop.Liab.Malpract				1,224	1,224
39	Total		\$			\$ 176,790	\$ * 176,790

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Colfax# 0041020Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	27 Other	\$	Heritage Enterprises, Inc.		\$ 0	\$
16	V	30 Depreciation				6,976	6,976
17	V	31 Amortization of Pre-Op & Org				0	
18	V	32 Interest				0	
19	V	33 Real Estate Taxes				0	
20	V	34 Rent-Facility & Grounds				3,971	3,971
21	V	35 Rent-Equipment & Vehicles				1,563	1,563
22	V	36 Other				0	
23	V	38 Medically Nec Transportation				0	
24	V	39 Ancillary Service Centers				0	
25	V	40 Barber and Beauty Shops				0	
26	V	41 Coffee and Gift Shops				0	
27	V	42 Other				0	
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 12,510	\$ * 12,510

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Colfax # 0041020 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Susie Jefferson	Director	Management	15.86		10		Salary/BOD	\$ 1,996	Ln. 17/18	1
2	Tom Jefferson	Secretary	Management	16.21		10		Salary/BOD	8,566	Ln. 17/18	2
3	Craig Hart	Chairman	Management	31.95		10		Salary/BOD	10,846	Ln. 17/18	3
4	Cheryl Lowney	Executive Vice President	Management	0.49		40	100.00	Salary/BOD	5,900	Ln. 17/18	4
5	Steve Wannemacher	President	Management	0.42		40	100.00	Salary/BOD	7,870	Ln. 17/18	5
6	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Salary	3,912	Ln. 17/18	6
7	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Salary	4,511	Ln. 17/18	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 43,601		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Manor-Colfax# 0041020

Report Period Beginning:

01/01/2004Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1 Dietary	Beds	2,403	24	\$ 89,729	\$ 89,729	60	\$ 2,240	1
2	2 Food Purchase	Beds	2,403	24	0	0	60	0	2
3	3 Housekeeping	Beds	2,403	24	0	0	60	0	3
4	4 Laundry	Beds	2,403	24	0	0	60	0	4
5	5 Heat & Other Utilities	Beds	2,403	24	27,471	0	60	686	5
6	6 Maintenance	Beds	2,403	24	321,832	76,617	60	8,036	6
7	7 Other	Beds	2,403	24	0	0	60	0	7
8	9 Medical Director	Beds	2,403	24	0	0	60	0	8
9	10 Nursing & Medical Records	Beds	2,403	24	0	0	60	0	9
10	11 Activities	Beds	2,403	24	0	0	60	0	10
11	12 Social Service	Beds	2,403	24	0	0	60	0	11
12	13 Nurse Aide Training	Beds	2,403	24	47,533	39,159	60	1,187	12
13	14 Program Transportation	Beds	2,403	24	0	0	60	0	13
14	15 Other	Beds	2,403	24	0	0	60	0	14
15	17 Administrative	Beds	2,403	24	1,615,588	1,615,588	60	40,339	15
16	18 Directors Fees	Beds	2,403	24	130,630	0	60	3,262	16
17	19 Professional Services	Beds	2,403	24	410,747	0	60	10,256	17
18	20 Fees, Subscription, Promotions	Beds	2,403	24	88,297	0	60	2,205	18
19	21 Clerical & General Office Expense	Beds	2,403	24	3,252,161	2,929,944	60	81,203	19
20	22 Employee Benefits & Payroll Tax	Beds	2,403	24	837,746	0	60	20,918	20
21	23 Inservice Training & Education	Beds	2,403	24	13,283	0	60	332	21
22	24 Travel and Seminar	Beds	2,403	24	196,325	0	60	4,902	22
23	25 Other Admin. Staff Transportation	Beds	2,403	24	0	0	60	0	23
24	26 Insurance-Prop.Liab.Malpract	Beds	2,403	24	49,040	0	60	1,224	24
25	TOTALS				\$ 7,080,382	\$ 4,751,037		\$ 176,790	25

Facility Name & ID Number Heritage Manor-Colfax# 0041020

Report Period Beginning:

01/01/2004Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27 Other	Beds	2,403	24	\$	\$	60	\$	1
2	30 Depreciation	Beds	2,403	24	279,369		60	6,976	2
3	31 Amortization of Pre-Op & Org	Beds	2,403	24			60		3
4	32 Interest	Beds	2,403	24			60		4
5	33 Real Estate Taxes	Beds	2,403	24			60		5
6	34 Rent-Facility & Grounds	Beds	2,403	24	159,040		60	3,971	6
7	35 Rent-Equipment & Vehicles	Beds	2,403	24	62,608		60	1,563	7
8	36 Other	Beds	2,403	24			60		8
9	38 Medically Nec Transportation	Beds	2,403	24			60		9
10	39 Ancillary Service Centers	Beds	2,403	24			60		10
11	40 Barber and Beauty Shops	Beds	2,403	24			60		11
12	41 Coffee and Gift Shops	Beds	2,403	24			60		12
13	42 Other	Beds	2,403	24			60		13
14							60		14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 501,017	\$		\$ 12,510	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1	LsSalle National Bank		xx	Mortgage	4640 plus Int	01/15/99	\$		\$	722,502	01/15/06	variable	\$	26,728		1			
2	LsSalle National Bank		xx	Mortgage										5,484		2			
3																3			
4																4			
5																5			
	Working Capital																		
6	Central Office Allocation		xx	Working Capital										6,652		6			
7	Central Office Allocation		xx	Working Capital												7			
8																8			
9	TOTAL Facility Related							\$		\$	722,502			\$	38,864		9		
	B. Non-Facility Related*																		
10	Interest Income													(79)		10			
11																11			
12																12			
13																13			
14	TOTAL Non-Facility Related							\$		\$				\$	(79)		14		
15	TOTALS (line 9+line14)							\$		\$	722,502			\$	38,785		15		

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Heritage Manor-Colfax**# **0041020** Report Period Beginning: **01/01/2004** Ending: **12/31/2004****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2003 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	24,803	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	26,060	2
3. Under or (over) accrual (line 2 minus line 1).			\$	1,257	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	27,363	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	28,620	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999	17,575	8	
		2000	20,995	9	
		2001	26,915	10	
		2002	25,138	11	
		2003	25,336	12	
		FOR OHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2003	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME	Heritage Manor-Colfax	COUNTY	McLean
---------------	-----------------------	--------	--------

CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Page 10A

A. Square Feet:

13,016

B. General Construction Type:

Exterior

brick/wood

Frame

wood

Number of Stories

C. Does the Operating Entity?

xx

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

xx

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

xx

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	land			\$ 43,000	1
2					2
3	TOTALS			\$ 43,000	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60				\$ 840,000	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1995 Improvements			1995	38,109						9
10											10
11	Remodel---Interior Walls			1997	7,439						11
12	Addition			1997	5,229						12
13	Paint/Remodel Resident Room			1996	1,728						13
14	Kitchen A/C Unit			1996	3,125						14
15											15
16	Interior Remodel-Materials			1998	73,979						16
17	Roof Replacement			1998	67,876						17
18	Interior Remodel-Labor			1998	2,612						18
19											19
20	ALTA Survey			1999	2,862						20
21	Professional Fees			1999	1,900						21
22	Water Temp Control			1999	1,440						22
23											23
24	Interior Remodel -- Materials			2000	12,700						24
25	Interior Remodel -- Professional Fees			2000	698						25
26											26
27	Water Softener			2001	4,075						27
28	Generator			2001	1,827						28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							6,977	6,977		34
35	Book Depreciation					44,114		44,114		359,158	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	2 Year Constructed	3 Cost	4 Current Book Depreciation	5 Life in Years	6 Straight Line Depreciation	7 Adjustments	8 Accumulated Depreciation	9
37			\$	\$		\$	\$	\$	37
38	Seal Parking Lot	2002	750						38
39	A/C Unit	2002	2,528						39
40									40
41	Exit Doors	2003	2,892						41
42	Phone System	2003	5,958						42
43	A/C Unit	2003	1,941						43
44	Water Heater	2003	4,375						44
45	Friedrich Wallmaster	2003	1,294						45
46									46
47	A/C Unit	2004	8,164						47
48	Window Glazing	2004	1,578						48
49	Sidewalk	2004	3,479						49
50	Ansul System	2004	1,305						50
51	Seal Parking Lot	2004	820						51
52	Shower Room	2004	5,355						52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,106,038	\$ 44,114		\$ 51,091	\$ 6,977	\$ 359,158	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 234,378	\$ 21,735	\$ 21,735	\$		\$ 195,534	71
72	Current Year Purchases	10,335						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 244,713	\$ 21,735	\$ 21,735	\$		\$ 195,534	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,393,751	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 65,849	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 72,826	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,977	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 554,692	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 4,639 Description: pager, computer equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____
		HOURS PER AIDE _____	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		101		101
3	Classroom Wages (a)		354		354
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	455	\$	455
10	SUM OF line 9, col. 1 and 2 (e)	\$	455		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 49,749	\$		\$ 49,749	1
2	Licensed Speech and Language Development Therapist		hrs			18,777			18,777	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			59,016	130		59,146	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				200,329		200,329	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					9,204			9,204	13
14	TOTAL			\$		\$ 136,746	\$ 200,459		\$ 337,205	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Heritage Manor-Colfax

0041020

Report Period Beginning: 01/01/2004

Ending:

12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2004

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,164	\$	1
2	Cash-Patient Deposits	2,963		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	250,839		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,423		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(453,839)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (183,450)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	43,000		13
14	Buildings, at Historical Cost	1,106,038		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	244,713		16
17	Accumulated Depreciation (book methods)	(554,692)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	5,484		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 844,543	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 661,093	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 44,528	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,963		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	80,670		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,357		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,363		32
33	Accrued Interest Payable	2,712		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 173,593	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	722,502		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 722,502	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 896,095	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (235,002)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 661,093	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (264,182)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (264,182)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	29,180	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 29,180	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (235,002)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,148,071	1
2	Discounts and Allowances for all Levels	(439,085)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,708,986	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	328,579	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 328,579	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	3,868	11
12	Gift and Coffee Shop	636	12
13	Barber and Beauty Care	5,551	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	228,985	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	31	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 239,071	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	79	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 79	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,276,715	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	416,977	31
32	Health Care	1,070,966	32
33	General Administration	595,575	33
B. Capital Expense			
34	Ownership	138,755	34
C. Ancillary Expense			
35	Special Cost Centers	4,862	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37		20,400	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,247,535	40
41	Income before Income Taxes (line 30 minus line 40)**	29,180	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 29,180	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heritage Manor-Colfax

0041020

Report Period Beginning: 01/01/2004

Ending:

12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,077	2,442	\$ 51,000	\$ 20.88	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	2,532	2,873	57,132	19.89	3
4	Licensed Practical Nurses	6,329	6,656	135,999	20.43	4
5	Nurse Aides & Orderlies	34,667	37,168	405,154	10.90	5
6	Nurse Aide Trainees	50	50	354	7.08	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	2,348	2,734	25,929	9.48	10
11	Social Service Workers	2,112	2,223	24,271	10.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,015	14,527	138,783	9.55	15
16	Dishwashers					16
17	Maintenance Workers	2,060	2,157	30,697	14.23	17
18	Housekeepers	4,956	5,180	41,492	8.01	18
19	Laundry	4,267	4,577	36,554	7.99	19
20	Administrator	1,900	2,080	51,597	24.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,313	3,892	69,544	17.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	79,626	86,559	\$ 1,068,506 *	\$ 12.34	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		7,200		36
37	Medical Records Consultant		1,008		37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,302		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,889		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 12,399		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 15,871		50
51	Licensed Practical Nurses		28,015		51
52	Nurse Aides		745		52
53	TOTAL (lines 50 - 52)		\$ 44,631		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes	F. Dues, Fees, Subscriptions and Promotions
Name	Function	%	Amount	Description	Amount
Susan Holified			\$ 51,597	Workers' Compensation Insurance	\$ 22,185
				Unemployment Compensation Insurance	16,916
				FICA Taxes	81,741
				Employee Health Insurance	82,996
				Employee Meals	
				Illinois Municipal Retirement Fund (IMRF)*	
				Employee Hepatitis Vaccine	0
				Employee Benefits -	16,966
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 51,597	Employee Benefits - central office	20,918
(List each licensed administrator separately.)					
B. Administrative - Other					
Description			Amount		
			\$		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V,	\$ 241,722
(Attach a copy of any management service agreement)				line 22, col.8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees	
Vendor/Payee	Type		Amount	Description	Line # Amount
Heritage Enterprises	Mgt Fees		\$ 142,634		
			0		
			0		
			0		
			1,075		
			0		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 143,709	TOTAL	\$
(If total legal fees exceed \$2500 attach copy of invoices.)					
				G. Schedule of Travel and Seminar**	
				Description	Amount
				Out-of-State Travel	\$
				In-State Travel	
					1,655
					54
				Seminar Expense	2,928
					(7,540)
					4,902
				Entertainment Expense	(
				(agree to Sch. V,	
				line 24, col. 8)	\$ 1,999
				TOTAL	

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO xx If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 32,940
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 13,209
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Sulaski & Webb The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. Not available at this date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

